City of Memphis MEDICARE RETIREE CHANGE FORM

2011

NOTE: Only complete if you wish to change plans, add or delete dependents to your health coverage

EMPLOYEE INFORMATION

Employee Name (Last Name, First Name, Middle Initial)

List PCP ID Number

Social Security Number — —

Sex (M or F)

Date of Birth – MM/DD/YY

Street Address

City **State** **Zip**

Daytime Phone Number ( ) -

Evening Phone Number ( ) -

Division

E-Mail Address

COMPLETE ALL THAT APPLIES

☐ RETIREE ☐ SURVIVOR

☐ CITY OF MEMPHIS BASIC
☐ CITY OF MEMPHIS PREMIER
☐ CITY OF MEMPHIS BASIC ADVANTAGE
☐ CITY OF MEMPHIS PREMIER ADVANTAGE

☐ ADD ☐ DELETE ☐ CANCEL

YOUR PLAN WILL COVER

☐ FAMILY ☐ SINGLE

EMPLOYER USE ONLY

EFFECTIVE DATE EMPLOYEE / /

EFFECTIVE DATE DEPENDENT(S) / /

TERMINATION DATE / /

ENTERED BY

DIVISION CODE

HIRE DATE: / /

List all dependents you wish to _____ ADD TO YOUR COVERAGE or _____ DELETE FROM YOUR COVERAGE or _____ UPDATE SOCIAL SECURITY NUMBER on your coverage.

Last Name	First Name	Initial	Social Security Number	Date of Birth (MM/DD/YY)	Sex (M or F)	Full Time Student (YES / NO)	For Premier ONLY (List PCP ID Number)
Spouse							
Dependent							
Dependent							
Dependent							

If you or your dependents are covered by other group insurance, please fill out the following information:

Name of Person covered by other insurance

Social Security Number

Name of Company this Person works for

Group No.

Name of other Insurance Company

Effective Date:

List dependents Covered:

Medicare ☐ Yes ☐ No

If yes: ☐ Part A ☐ Part B ☐ Part D

Effective Date / /

Medicare HICN:

Name: **Relationship:**

Comments:

By signing below, I certify that: the information provided above is true and correct. I accept the plan rules as set forth by the City of Memphis; and I authorize payroll deduction for the plan above.

Form must be completed and signed by City employee to be accepted.	NOTARY SIGNATURE	NOTARY EXPIRATION DATE
Signature **Date**		

City of Memphis Benefits Office, 125 N. Main, Ste. 438, Memphis, TN 38103 (901) 576-6761